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Physicians' Experiences of Touch, a Hermeneutic Reflection

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Abstract

Touch is central to clinical practice but can be a "touchy subject" in medical education, simultaneously associated with care, and risk. In the clinical literature, touch is typically categorised as communicative or procedural, with an emphasis on touch as behavioural. Philosophically, touch is also a subject of consideration, yet this literature remains relatively unfamiliar to clinicians. In this essay, I reflect on touch in healthcare and medical education, as explored in my PhD studies, drawing on the work of hermeneutic philosophers, particularly Merleau-Ponty. Interpreting touch, I propose, is inherently hermeneutic, offering many possibilities to deepen our understanding of human interaction and clinical practice. Touch embodies the clinician-patient relationship as a holistic encounter. In high intensity interactions, touch orientates expression of empathy "beyond words." I present the significance of hermeneutics for clinical education, to richly re-imagine, and challenge, the concept of patient-centredness.

Keywords

Touch, healthcare, senses, body, language

Touch in clinical practice is both familiar and strange. It "falls into the in between*"* (Gadamer, 2004, p. 306) bridging philosophy and practice. The universal sense (Aristotle, c.350 BC as cited in Durrant, 2015), touch accompanies and signifies the human journey through life – babies nurse at their mother's breast, toddlers explore their world through touch, the rough and tumble of childhood years, replaced by tantalizing tingles of burgeoning sexuality, sealed with a kiss of marriage. As nature repeats the cycle of life, we hold the hands of our loved ones, through diagnosis of illness, to parting at death. Yet touch, in contemporary society, is a "touchy subject." Healthcare professionals in particular worry about "inappropriate touch," fearful of triggering

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trauma or crossing boundaries of age, gender, or culture. During the COVID 19 pandemic, touch became taboo; hazard signs warned of perils of contamination and promoted touch avoidance. Concurrently, society experienced "touch hunger," a phenomenon which describes hankering for human connection (Field, 2014). Healthcare crystallized many of these dilemmas, juggling the jeopardy of infection with the tragedy of dying inaccessible and alone.

It is in this context I share my experiences and thinking on touch as a physician educator. A few years ago, a hug bestowed by an elderly patient, called me to question touch in medical practice. I was curious to understand my colleagues' experiences of touch; if, how, when they touch a patient – to the extent I conducted my PhD on the topic. (Kelly, 2019). At the time, I could not have anticipated the move from bedside and clinic to "virtual care;" the rapid adoption of a new cybernetic space to deliver patient care. In 2021, consequent to the COVID-19 pandemic, approximately 73% of Canadians had at least one virtual health care interaction (Canadian Institute for Health Information, 2022). Many question the role of virtual care, (Canadian Institute for Health Information, 2022; Mann et al., 2020; Moynihan et al., 2021) and to what extent it will transform healthcare. Do we live in a new era of "hands off" healthcare and what are the implications for health professions education?

I do not have all the answers but in this essay invite you to ponder with me the role of touch in contemporary health care and health professions education. I will draw on empirical studies that formed the basis of my PhD. My thinking has evolved since then and like many healthcare professionals, I grappled during the COVID-19 pandemic and with a radically changing culture, one in which health and social inequities became more visible, but ironically, I suggest, less felt. Our societal ability to be touched by the suffering of another, seemed questionable at times. The role of healthcare personnel "*to cure sometimes, relieve often and care always*" (Shaw, 2009, p. 995) never felt so challenging and simultaneously so rewarding, often demonstrated through clinical touch, or lack thereof. This essay is presented in three sections, as I reflect on touch in healthcare and health professions education, its past, the present, and future.

The Past

The Whole of the Parts

The relationship between touch and healing is entrenched in history. Kearney eloquently traces the connection between hands-on practice, healing, touch, and knowledge in his recent book *Touch* (Kearney, 2021). He reminds us of classic tales from Ancient Greece. Chiron, son of Zeus, taught Asclepius, first patron of medicine, the healing power of touch – healing involved bathing, massage, and the application of soothing herbs. In the second century, Roman physician Galen, described the role of the senses in medical treatment, and for Galen and his followers, touch played a key role– "*medicine was above all a tactile science"* (Wootton, 2006, p. 63, as cited in Howes & Classen, 2013). Galen described in elaborate detail recording of the pulse – its strength, hardness, speed, interval, regularity, and rhythm, a tradition which persists, albeit to a lesser degree, to this day (Talley & O'Connor, 2021).

The bible preserves the association between touch and healing; Jesus heals the Leper and calls out "*who touched me,"* when a woman touches his cloak. The rich association between touch,

healing (physical and spiritual) and life is readily apparent in Western art, evidenced in the work of Michelangelo's *Creation of Adam* or Carravaggio's *The Incredulity of Thomas*. In the Middle Ages, touching relics or, as possibilities of reproduction of art improved, religious images was linked with healing. It was believed that any ailment, no matter how dire, could be cured by touch; different saints became associated with different ailments and abilities to cure by touching their relics. Touching religious objects or placing them on the afflicted part of the body was associated with the transmission of spiritual holiness and physical wholeness (Classen, 2012). As history unfolds, the power of God became synonymous with the divine power of royalty. In both England and France, the royal touch could cure scrofula; ceremonies were scheduled and crowds would gather, hopeful for the royal remedy of touch (Howes & Classen, 2013).

In these accounts, the attention to healing is not based on a science of illness but healing is represented as restorative of the whole person. Healing is holistic. Healing, according to Gadamer, means "*to make whole"*; it's not only the successful struggle against illness but care for health in its broadest sense (Gadamer, 1996). Whole extends beyond the confines of body and mind of the individual (and historically could include the family of the afflicted). Whole refers to the harmony that is the interconnectedness of man in the world and how we are all linked, caught in the flux of humanity, partners in a shared lifeworld. This idea is echoed in the present day by the World Health Organization (WHO) definition of health as not merely the absence of disease but as a state of complete physical, mental and social well-being (WHO, n.d.). A definition which, at times, feels at odds with patient experiences of healthcare, and for health professional learners, how it is taught.

The Parts of the Whole

"Cogito, ergo sum" Descartes' (1596–1650) (Descartes, 2000) legacy divides the whole into parts – the palpable body, the intangible mind. Descartes was born some fifty years after the publication of *Fabrica* (1543), Vesalius' influential anatomical text. It is possibly here that the metaphor of the body as machine originated – veins, arteries, and nerves are described as pipes. (Bleakley, 2017). Descartes referred to the body as a machine and many of the subsequent metaphors remain part of modern-day history taking. I may ask, for example, a patient about "his plumbing" (urinary tract) or "ticker" (heart). Advances in neurophysiology make use of references to electrical systems, and we talk of the brain as a computer. Machines can be broken down, examined in pieces – engines repaired with replacement valves. But metaphors, as Ricoeur (2004) reminds us, have generative power, extending meaning beyond the apparent.

The Present

Learning in Parts

Let us peer behind the metaphor of man as machine, to understand what is being said and, to listen to what is silenced (Moules, 2002) – or perhaps forgotten as we speculate on the meaning of touch in medical practice. Heidegger reminds us that words and language are not wrappings in which things are packed, but rather – language is the master of man (Heidegger, 2010). To what extent has the dominant rhetoric of "man as machine" organized our experience and perception of the body, and touch in clinical practice and education? Importantly, what is being valued and

what is being devalued – or as we play hermeneutically – what is revealed and concealed by this language? Bleakley suggests it is inevitable that, a mechanical notion of the body produces a mechanical notion of health care (Bleakley, 2017). Consequently, a culture working within a mechanical model of medicine will attend to the sorts of interventions that are observable and measurable. The body is transformed into systems, each learned separately, sequentially. Skills to interrogate each system, for example, canulation, are learned in compartmentalized modules. In contemporary care, the metaphor of the machine has been supplanted by an increasingly sophisticated technology; SimMan (Laerdal, n.d.) – a life-size plastic model, replete with monitors that beep and display the pulse and breathing rate, has replaced the tactile body. A technological prestige which risks suppressing the role of the senses in diagnosis and treatment.

The metaphor is perpetuated in our clinical language. As language is our House of Being (Heidegger, 2010) our ability to express touch linguistically is vast – verbs for action, adjectives to qualify, nouns of texture. Yet, perhaps, at least in medical practice, the language we use is quite limited. Textures in medicine are often "hard, firm, or soft," objective and lacking the rich subjective description of touch used in everyday interactions. Verbs are active and authoritative. Let me share some that are familiar to me; as a physician I *conduct* a physical examination, I *perform* a procedure, I *excise* a lump, which I describe as soft, firm, hard. Physicians probe, measure, cut; we may, on occasion, pat someone on the arm. A language of action predominates over one of sensation; the body of the patient is silent, compliant, and devoid of agency. Learning the language of a profession is an important rite of passage, legitimizing membership. Language lives in the learning environment. In medical education, early learning takes place in a clinical skills laboratory. In the past, anatomy was often learners first encounter with the body – and the literature is replete with accounts of the impact this had on students (Hodges, 2004; Kelly, 2011). Prosection, where the natural anatomy has been prepared, cleaned, perhaps even preserved with plastic, has, in the majority, replaced dissection. The anatomy lab is replaced by the clinical skills laboratory. The clinical skills lab – as conjured by the word, is clean, sterile, often a mocked-up version of a hospital ward: beds, with no privacy. Technology and sophisticated simulators are the focus of the clinical gaze. Bodies are replaced by (programable) mannequins. The body is replaced by disembodied dismembered plastic parts – a pelvis without legs, an arm without a trunk. Gender and race sporadically appear, usually as biologically significant. As students learn to feel pathology, their hands press on plastic, slightly sticky from a previous learner's hands, or sanitizer. Models, over time, become slack or stiff. The objective of the task is to find the abnormality, rather than appreciate the subjective normality of healthy tissue. No sweat gets stuck under fingernails, no slimy mucus to remove from the cervix, no clothes to fumble around. The bodywork of care, preparing the room, cleaning up vomit, delegated to assistants or technical staff. The warm, fleshy, visceral, responsive body of bedside teaching is obsolete. Learning has moved from proximity to proxy, from incarnate to excarnate. (Kearney, 2021).

Practicing as Whole

From learning laboratory to clinical practice. During my research, I interviewed physicians of different ages from different disciplines about their experiences of touch. "*Tell me about an experience you've had as a physician that involves touch"* I asked "*it can be from yesterday, last week or last year….but I'd like you to describe it in as much detail as you can."* Physicians

initially puzzled, started hesitantly; the word 'touch' felt strange – they countered – "*Do you mean an example from clinical examination or ….?". "Any example that comes to mind"* I responded. Interviews started slowly, participants feeling their way into the topic. Some interviews lasted over two hours, participants probed their own experiences *"Why did this encounter stay with me?"* they remarked. *"What does touch really mean?"* – a physician pauses perplexed to recall if he physically touched a patient of if *"the connection was in my head – does it matter?,"* he wondered.

"You develop a sense of what is normal …and it becomes part and parcel of your innate senses" (Neonatologist). Perhaps, one of the reasons physicians struggle to describe touch, is it has become embodied. Exit Descartes, enter Merleau-Ponty; the physician body, becomes *"my point of view"* of the world. "*The body … as our means of communication with [the world], … as the horizon latent in all our experience and itself ever-present and anterior to every determining thought"* (Merleau-Ponty, 1962, pp. 91-92). To help clarify this experience of the body as living (experienced), Husserl, later re-enforced by Merleau-Ponty, used the term *Leib*, distinguishing such experience from the body-object (*Körper).* Physicians described, *"going through the motions"* of physical exam and complex technical procedures. A neonatologist explained the awe people have for what she does – how can she place tubes in tiny pipes – but it's *"automatic"* for her. She doesn't "think" about it. The same story – different disciplines: radiology, surgery, family medicine, obstetrics; repeated touching – directly or via instruments - becomes second nature. Here we encounter what Merleau-Ponty described as the habitual body – "*Body schemata…are 'ready-made systems of equivalents and transpositions from one sense to the other'"* (Merleau-Ponty, 1962, p. 235).

Habitual performance of physical examination resulted in a "*rearrangement and renewal of the corporeal schema"* (Merleau-Ponty, 1962, p. 142). The body [schema] becomes the reference point, establishing a stable perceptual background; a site of integration of past experiences, prior learnings, or skills which change from being fragmented to being embodied, to the extent that participants no longer needed to think about them. Similar to Leder's (Leder, 1990) notion of the *"absent body,"* the physician's body becomes absent, fading into the background, only to speak up when something goes wrong.

When the body speaks, she speaks through all the senses. Physicians described with intensity, experiences when they encounter "*moments of mismatch"* (Harris, 2011) to reveal the body in the moment. A family physician described feeling a breast lump which she suspected was malignant. She recounted feeling with her hands, listening to her own heartbeat as it thumped in her chest, seeing, searching in the patient's eyes as the patient's eyes touch hers. The moment was "*full-body-brain."* Boundaries blurred – the senses are entangled; the body of the patient and the physician were indistinguishable, reminiscent of Merleau-Ponty's idea of the "chiasma," a crisscrossing of bodies and world – "*I live in the facial expressions of the other, as I feel him living in mine*" (Merleau-Ponty, 1964, p. 146). Time went slower, as the physician recounted the moment in detail, but the touch was also suspended in time; I realized after the interview, this event happened years previously. Perception is *"achieved[d] with our whole body all at once"* (Merleau-Ponty, 1962, p. 225). The unity of the intersensory thing is "*constituted in the hold which my body takes upon it"* (p. 320). The physician's body not as a collection of organs but a *"syngeneic system,"* radiating existential possibilities of intersubjectivity.

Healing, to make whole, sometimes feels impossible. My heart breaks when I hear some of my patient's stories. I see people hurting and my science cannot combat the inequities and harm, often unwittingly inflicted on the other. Lives fragmented, revealed in pieces. Many of my participants recounted experiences, however, which conveyed a sense of healing, even if momentary. I am not sure, sometimes, who was being healed – physician or patient. An intensive care physician describes touching a patient's hand during rounds; a surgeon similarly holds a patient's hand as the anesthetic agent seeps into the bloodstream. Small gestures, small moments of interconnection, shared life-worlds of vulnerability, responsibility, and trust, a shared "experiential flux."

A young physician holds an ultrasound probe, smoothly gliding over a pregnant abdomen. The patient is expecting twins. The first heartbeat is immediate but after the gel has been applied several times, and her tummy shines with a search for a rapid lub-dub, lub-dub, the probe slows and stills. Silence. Two pairs of eyes swivel from the screen to each other. The physician had experienced a similar situation in her own pregnancy – a twin pregnancy which resulted in a single birth. She perceives the moment when the mother realizes, one baby alive, one baby dead. She sees shock, fear… she does not know what. For in that moment, the doctor recognizes that although she has had a similar experience, it is not the same. She does not know what this woman is feeling, thinking, perceiving. She puts the probe down and touches the woman's hand. Touch "speaks" an ethical response to the concrete experience of the other, creating a space where physician and patient are present for each other (Large, 2015).

"*Empathy is not a feeling of oneness*" (Stein, 1989, p. 17). Understanding comes from perceiving the differences between the Other and the observer. The selfness of "I," she argued, is "*brought into relief in contrast with the otherness of the other*" (Stein, 1989, p. 38). Meeting the Other is a *"chiasm*" in which people are "*two openesses*" (Merleau-Ponty, 1968, p. 213). Touch, as embodied, empathic communication between physician and patient opens us to the invisible connection that unites us as people participating in a shared lifeworld, other orientated.

"*Once a body-world relationship is recognized, there is a ramification of my body and a ramification of the world and a correspondence between its inside and my outside and my inside and its outside*" (Merleau-Ponty, 1968, p. 136). I suggest that in such "touching moments" the body of the physician becomes changed, somehow "moments of meeting" imprint on our body; the intersubjective experiences, as a point of view on the world, is carried forward, as a new horizon of understanding.

The Future

Restoring the Whole

When I wrote my thesis, my focus on touch was, in essence, a call to re-embody clinical practice and health professions education. To resuscitate "*the Leib"* of clinical praxis, as essential as *"Körper."* Clinical practice is neither subjective nor objective; healing starts in the in between, the intersubjective space of being-with-others (*mitsien*). Starting with my personal experience and discovering I was not alone, I wanted to draw attention to the undocumented but perceived

ways in which clinicians and patients encounter each other, often at a primordial level – we respond, without knowing or comprehending the Other (Large, 2015); it is the Other that calls us into being. This ethical call is at the heart, for me, of being a health professional, pre-cognitive, pre-affective. Ironically, it is when touch becomes cloaked in rationality and social constructions that it becomes unethical. Thus, the task, which I feel is incomplete (my attempts in this essay, I hope raised many questions for you), remains to restore touch to its original difficulty (Caputo, 1988; Moules et al., 2015). Touch is complex, messy, encountered in "moments" which appear fleeting but embody our shared humanity. Health encounters, like most experiences in life which are worthwhile, involve risk. We cannot and should not seek to reduce the complexity and wonder of what it is to be human to logarithmic behaviourist platitudes – it's okay to touch *here* but not *there*. To do so in healthcare and health profession education risks, I suggest, reducing touching to transactional medicine which belies the beauty of embodied experience as central to our encounter with another. Of course, I cannot as a teacher, deny that deconstructing concepts to help understanding is important – essential even. But this risks fragmenting experience in an artificial way - ways that do not reflect how we practice. Perhaps it is simply that in our efforts to structure care and learning, we have just forgotten the importance of stepping back and seeing – and teaching - the importance of the whole.

Coda

A curious reader may ask – hmm, so what has changed since the COVID-19 pandemic? It looks like virtual care is here to stay; it facilitates access to care, and reduces transport time and costs, contributing to planetary health – where does touch fit now? My reflection, perhaps strange, is that not much has changed. While virtual care helps with many administrative, and relatively simple transactions, people in distress still need to be "seen." Part of being "seen" is being heard, and being felt – felt, not just in terms of physical examination but felt as in having their presence acknowledged. For those requiring in-person care, that care continued through the pandemic and continues. The pandemic did, however, heighten societal awareness of touch, physical contact, and our interconnectedness. It showcased the intersensory ways in which we communicate; for many patients and physicians, virtual visits, while satisfactory "miss" a certain element, a presence, an acknowledgement. It reminded us of that humans need each other and we are interconnected in ways that include and extend beyond the physical and verbal.

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